Patient Information Update

Confidential Patient Information

Last Name: ______________________________First Name: _____________________________ MI: ____ D.O.B: __________

Address: ____ City: _________________ State: _____ Zip Code: ___________

Marital Status: ❑Single ❑ Married ❑ Widowed ❑ Minor

Employer: _____________________________ Occupation: _____________________________ Years Employed: ________

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: ______________________

Email Address: ____

Any Changes to Your Dental Insurance? ❑ Yes ❑ No If yes, please update dental insurance info below:

Dental Insurance Information (Primary Carrier)

Insured's Name: _____________________________________ Relationship to Patient: ❑ Self ❑ Spouse ❑Parent ❑Other

Insurance Company: ______________________________________ Insurance Telephone: ________________________

Insurance Company Address: ____

City: ____ State: ______________ Zip Code: ________________________

ID #: _______________________ Group #: ___________________________ Policy Holder's DOB: __________________

Policy Holder's SS#: _____________________________ Policy Holder's Employer: ____________________________________

Secondary Dental Insurance Information

Insured's Name: _____________________________________ Relationship to Patient: ❑ Self ❑ Spouse ❑Parent ❑Other

Insurance Company: ______________________________________ Insurance Telephone: ________________________

Insurance Company Address: ____

City: ____ State: ______________ Zip Code: ________________________

ID #: _______________________ Group #: ___________________________ Policy Holder's DOB: __________________

Policy Holder's SS#: _____________________________ Policy Holder's Employer: ____________________________________

Emergency Contact Information

Emergency Contact: ___________________________________ Relationship to Patient: ______________________

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: _____________________

Authorization and Consent

I authorize the Song Dental to take radiographs, study models, photographs, or any diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I authorize the Doctor to perform any and all forms of medication, and therapy that may be indicated and agreed upon. I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

Initial: ___________

Your Future Appointments

We realize that illness, emergencies, and changes in work or school schedules occasionally occur. Please understand that when we schedule your appointment, we are reserving time for your particular needs. Your commitment to yourself is to **KEEP YOUR SCHEDULED APPOINTMENT**. We will always make every effort to accommodate your scheduling needs and keep our schedule "on time." If you are unable to keep your scheduled appointment, we require a **48-hour** notice (2 full days) so that we may accommodate the dental needs of another patient.

Initial: ___________

Financial Information

As a courtesy, Song Dental will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. I authorize this office to submit insurance claims and to contact my insurance company on my behalf. I understand that any fee estimate provided by this office is NOT a guarantee of payment. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

Initial: ______________

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that I have certain rights to privacy regarding your protected health information. These rights are given to me under the Health Insurance Portability & Accountability Act (HIPAA). I have been given the opportunity to review & request a copy of the Notice of Privacy Practices for Song Dental. If I have any questions regarding the information in the Notice of Privacy Practices, I will reach out to Song Dental for additional information/clarification.

Initial: ______________

Medical History

Heart Conditions:

- ❑ Artificial Valve, Pacemaker, or Stent
- ❑ Arteriosclerosis
- ❑ Congestive Heart Failure (CHF)
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Low Blood Pressure

Blood Conditions:

- ❑ Abnormal Bleeding
- ❑ Anemia
- ❑ Blood Thinners (Coumadin, Plavix, Aspirin)
- ❑ Diabetes
- ❑ Hemophilia/Excess Bleeding
- ❑ Diabetes
- ❑ Stroke

Bone/Joint Conditions:

- ❑ Arthritis / Gout
- ❑ Artificial Joints (hip, knee)
- ❑ Osteoporosis
- ❑ Corticosteroid Medications

GI, Liver, Kidney Conditions:

- ❑ Acid Reflux / GERD
- ❑ Crohn's Disease
- ❑ Hepatitis A, B, or C
- ❑ Liver or Kidney Issues

Respiratory Conditions:

- ❑ Asthma
- ❑ Emphysema / COPD
- ❑ Chronic Bronchitis
- ❑ Sleep Apnea/CPAP
- ❑ Sinus Issues
- ❑ Snoring
- ❑ Tuberculosis

Cognitive / Mental Health:

- ❑ Anxiety
- ❑ Alzheimer's / Dementia
- ❑ Bipolar
- ❑ Depression

Women:

- ❑ Currently Pregnant
- ❑ Nursing
- ❑ Taking Oral Contraceptives

Allergic Reactions To:

- ❑ Aspirin or Ibuprofen
- ❑ Codeine or Other Narcotics
- ❑ Anesthetic / Epinephrine
- ❑ Penicillin/Amoxicillin Allergy
- ❑ Clindamycin Allergy
- ❑ Latex
- ❑ Nickel or other Metals
- ❑ Sulfa Drugs
- ❑ Other: ___________________

Other Conditions:

- ❑ Cancer: __________________
- ❑ Drug or Alcohol Abuse
- ❑ Fainting, Seizures, Epilepsy
- ❑ Fibromyalgia/Trigem Neuralgia
- ❑ Glaucoma
- ❑ Hearing or Sight Disability
- ❑ Hyper/Hypothyroidism
- ❑ HIV / AIDS
- ❑ Physical Limitations
- ❑ Tobacco Use

❑ **NONE OF THE ABOVE**

Do You Need to Pre-Medicate with Antibiotics Prior to Dental Procedures? ❑ Yes ❑ No

Have You Every Taken Fosamax, Boniva, Actonel, Reclast, or any other Meds Containing Bisphosphonates? ❑ Yes ❑ No

Please List All Medications and/or Supplements You Are Currently Taking:____

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____

Please Disclose Any Other Health or Medical Issues Not Listed Above: ______________________________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature (Parent/Guardian if under 18): ____ **Date**: ____ / ____ / _____